STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED		
		15E594	B. WING		06/01/2012
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE	
MCGIVA	EY HEALTH CARE	CENTED		136TH ST EL, IN 46033	
				IL, IIN 40033	<u> </u>
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
F0000					
	This visit was fo	or a Recertification and	F0000		
	State Licensure	survey. This visit			
	included the Inv	estigation of Complaint			
	IN00107420.				
	^	107420 - Substantiated.			
		ficiencies related to the			
		ted at F223, F225, F226,			
	and F309.				
	Survey dates: May 29, 30, 31, and June				
	1, 2012	iay 29, 30, 31, and June			
	1, 2012				
	Facility number:	000545			
	Provider number				
	AIM number: 1	00267350			
	Survey team:				
	1	.NTeam Coordinator			
		N. (5/29, 30, 31)			
	Melanie Strycke	r, R.N.			
	Cana				
	Census bed type				
	NF31 Total31				
	1018131				
	Census payor ty	ne·			
	Medicaid28	r - ·			
	Other3				
	Total31				
	Sample: 10				
					1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000545

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	00	——————————————————————————————————————	TE SURVEY IPLETED 01/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	cited in accordar	es reflect state findings ace with 410 IAC 16.2. //06/12 by Suzanne						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 2 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15E594	B. WIN			06/01/	2012
	PROVIDER OR SUPPLIER	CENTER	•	2907 E CARME	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033		(V5)
PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE BERGEDED BY ELLL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)					DATE
F0223 SS=D	483.13(b), 483.1 FREE FROM AE SECLUSION The resident has verbal, sexual, p corporal punishm seclusion. The facility must sexual, or physic punishment, or in Based on record facility failed to [Resident #C] was abuse from anoth and failed to ensuffly was free from [C.N.A. #3] whill The deficient praresidents reviewed abuse in a sample reviewed. Findings include 1. Tour of the factorial facto	a(b)(1)(i) BUSE/INVOLUNTARY at the right to be free from hysical, and mental abuse, nent, and involuntary not use verbal, mental, cal abuse, corporal hyoluntary seclusion. review and interview, the ensure a resident as free from physical her resident [Resident #I]; ture a resident [Resident myerbal abuse from staff the residing in the facility. Actice impacted 2 of 4 and for allegations of the of 10 residents : cility was initiated on A.M. with the Assistant fing [ADoN]. identified as an adriplegic with 2 healing	F02	TAG 23	DisclaimerPreparation, submission and implementatio of this Plan of Correction does constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Heat Care reserves all rights to cont the survey findings through informal dispute resolution, for appeal proceedings or any Administrative or legal proceedings. McGivney Healt Care reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers responses, credible allegations compliance and plan of correct as part of its ongoing efforts to provide quality care to resident McGivney Health Care reserves the right to modify policies and procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility. F223 It is the mission of this facility to provide its residents with a safe and pleasant	not alth test mal h e its s of tion ts. es	07/01/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 3 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPLET	ΓED
		15E594	A. BUILDI B. WING	DIL		06/01/20	012
		l .		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			136TH ST		
MCGI//N	EY HEALTH CARE	CENTER			L, IN 46033		
					, 114 70000	1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	ΓAG	·	I	DATE
	_	ment sheet included, but			environment in which to live. T facility will endeavor to preven		
	was not limited to, "[Resident #C] Special				report the mistreatment,	ι,	
	Needs: Uses ele	ctric wheelchair			investigate, neglect or abuse of	of I	
	quadriplegic"				all residents and the		
					misappropriation of property. T	he	
	On 5/30/12 at 2.	30 P.M., Resident #C's			facility will not tolerate verbal,		
	record was reviewed. Diagnoses				mental, sexual or physical abu	se,	
	included, but were not limited to,				corporal punishment or		
	· ·	· ·			involuntary seclusion, nor will i		
		are disorder, traumatic			allow any staff member to pun a resident at any time during a		
	brain injury, and spinal cord injury.				resident's stay in this facility.		
					MHCC reported these allegation	ons	
	A "Nurse's Notes" dated 5/27/12, late				to ISDH. Resident C and		
	entry, no time, ir	cluded, but was not			Resident I were immediately		
	limited to. "Resid	dent's [#C] roommate			separated. Residents C and I		
		acked resident no			were immediately assessed ar		
		les noted 15 minute			found without injury. Resident	!	
					was immediately moved to another room. Staff were pres	ont	
	·	Power of Attorney			with both residents during and		
	[POA] and docto	or notified"			throughout the incident until		
					Resident I was moved to anoth	ner	
	A "Physician's N	fote" dated 5/29/12, no			room and then put on 15minut	I	
	time, included, b	ut was not limited to,			checks. Both residents were		
	"Chief Complain	at: Sustained no injuries			referred to psych. services and	d	
		lted by roommate			seen by psychiatrist next		
	_	lent #C] was hit on the			visit.Resident H and CNA-3 we		
	_	mity bilateral Review			immediately separated by othe staff in the facility. The CNA-3	71	
	~	ke with resident today			was taken off schedule and		
		-			terminated. Resident H did not	t	
		discomfort, or injuries			recall the incident. No other		
	assessment revea	_			residents were affected by this	;	
	swelling, or injuries"				practice.The Facility's Abuse		
					Policy and Procedure was	,	
	On 5/30/12 at 3:05 P.M., during an				reviewed and revised. All staf	I	
		ent #C indicated his			are responsible to stop abuse report abuse immediately. Star		
	•	dent #I] attacked him on			in-service on MHCC ABUSE	"	
	_	given. He indicated the			PREVENTION POLICY AND		
	<i>5/2//</i> 12, 110 time	given. The mulcated the	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 4 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MU A. BUII		NSTRUCTION 00	COMPL	ETED	
		15E594	B. WIN			06/01/	2012
	PROVIDER OR SUPPLIER			2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	nurse [LPN #2] vabuse occurred. his roommate was the temperature is indicated Resided punched his right nurse [LPN #2] and Resident #I and varied Resident #I and varied Resident #I and varied Resident #I. Resident #II. Link #II. Link #III. Link #III. Link #III. Link #IIII. Link #IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	was present when the Resident #C indicated as upset at him related to an the room. Resident #C ant #I attacked him and at leg. He indicated the got between him and awas knocked down. cated Resident #I was an after approximately 2 and in bed. Resident #C ant #I was moved out of denied feeling fearful of dident #C indicated staff a lot. DO P.M., in an interview, ar indicated she was dent and would provide to date of the incident.			PROCEDURE (JUNE 2012) to the SSD/DON. All new emplowill receive and be in-serviced the MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) to hire. The DON/designee is the Abuse Investigation Coordination and will be responsible for utilizing the revised INVESTIGATIVE REPORT FOR SUSPECTED ABUSE, NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012) The Quality Assurance Committee will monitor compliance of the facility MHCABUSE PREVENTION POLICAND PROCEDURE for each incident and on a quarterly based on the service of the second incident and on a quarterly based on the service of the second incident and on a quarterly based on the service of the second incident and on a quarterly based on the service of the second incident and on a quarterly based on the service of the second incident and on a quarterly based on the service of the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and on a quarterly based on the second incident and the second incid	yees d on ipon e tor OR CC	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 5 of 35

	OF CORRECTION OF CORRECTION 15E594 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 01/2012
	PROVIDER OR SUPPLIER JEY HEALTH CARE CENTER	STREET A 2907 E	ADDRESS, CITY, STATE, ZIP O 136TH ST EL, IN 46033	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	#I [alleged violator] On 5/27/12 reportable sent to ISDH"				
	On 5/31/12 at 2:35 P.M., in an interview, CNA #1 indicated he was called to Resident #C and Resident #I's room by LPN #2. At that time, LPN #2 indicated to CNA #1 that Resident #I was beating Resident #C [prior to his arrival to the room]. CNA #1 indicated both residents were resting when he entered the room; however, he stayed in the room to monitor until LPN #2 returned. Upon her return, CNA #1 was instructed to stay with Resident #I until Resident #I was moved to a different room. CNA #1 indicated Resident #I was cooperative the rest of his shift.				
	The facility abuse policy and procedures were followed regarding the witnessed physical abuse of Resident #C from Resident #I.				
	2. On 5/31/12 at 10:40 A.M., Resident #I's record was reviewed. Diagnoses included, but were not limited to, anxiety, aphasia, hemiplegia non-dominant side, and cerebral vascular accident.				
	A "Nurse's Notes" dated 5/27/12 at 4:30 P.M., included, but was not limited to, "Resident [I] notified this nurse [LPN #2] that room too cold Resident [I] angry				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 6 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	COM	TE SURVEY PLETED	
		13034	B. WING			01/2012
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP (136TH ST EL, IN 46033	CODE	
				:L, IN 40033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Resident [C] con Resident [I] push onto roommate's started hitting the roommate [Resident There was no oth aggressive behave record. On 5/31/12 at 2:4 the Administrated was not physical residents or staff. The resident was situation, placed observation with another room and checks. 3. Following the 5/29/12 at 10:30 provided the invectompleted for an Resident #H and The facility's invindicated that on overheard by the another C.N.A. to The incident was	inplaining it was too hot ined this nurse [LPN #2] [Resident #C] bed and is nurse [LPN #2] and is nurse [LPN #2] and ident #C]" Iner documentation of vior in Resident #I's 45 P.M., in an interview, or indicated Resident #I ly aggressive with other imembers. Is removed from the on one to one of CNA #1 then moved to d placed on 15 minute The entrance conference on A.M., the Administrator estigation the facility of incident involving of C.N.A. #3. The estigation documentation of 4/2/11, C.N.A. #3 was of Charge Nurse and of "yell" at Resident #H.				
	Long Term Care	as required.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 7 of 35

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or condition	15E594	A. BUILDING	00	06/01/2012
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R		136TH ST	
MCGIVN	EY HEALTH CARE	CENTER		EL, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DETCENCT	DATE
	The follow-up in	vestigation indicated			
	[Resident #H] was trying to use the phone				
		call 911, and the C.N.A.			
		ner from doing so. The			
	_	d she argued in a raised			
		d her finger in [Resident			
	#H]'s face." The	C.N.A. also "reported			
		essed at work, and if her			
		educed (Saturday off),			
	she might do it again." The C.N.A. was immediately suspended				
	during the invest	• •			
	subsequently ter	_			
		he facility. A follow-up			
		in-service was given to			
	all other staff.	· ·			
	This Endamel	relates to Compleint			
	Inis Federal tag IN00107420.	relates to Complaint			
	11NUU1U/42U.				
	3.1-27(a)(1)				
	3.1-27(a)(1) 3.1-27(b)				
	3.1 27(0)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 8 of 35

, ,		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15E594	B. WING		06/01/2012
NAME OF D	PROVIDER OR SUPPLIER		STREET .	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER		2907 E	136TH ST	
MCGIVN	EY HEALTH CARE	CENTER	CARM	EL, IN 46033	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(i				
SS=D	INVESTIGATE/R ALLEGATIONS/I				
		not employ individuals who			
	have been found guilty of abusing,				
	neglecting, or mistreating residents by a court				
		ad a finding entered into the			
	State nurse aide	registry concerning abuse,			
	_	ment of residents or			
		of their property; and report			
	any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide				
	registry or licensing authorities.				
	109.04.7 01.1100.101	g aaeee.			
	The facility must	ensure that all alleged			
	violations involvi	ng mistreatment, neglect, or			
		injuries of unknown source			
		ation of resident property are			
		ately to the administrator of			
	-	other officials in accordance			
		rough established			
	certification ager	uding to the State survey and			
	Certification ager	icy).			
	The facility must	have evidence that all			
		s are thoroughly investigated,			
	_	t further potential abuse			
	while the investig	gation is in progress.			
	The " . " . "	tarrestantina a con			
		investigations must be			
		dministrator or his esentative and to other			
		dance with State law			
		State survey and certification			
		working days of the incident,			
		d violation is verified			
	appropriate corre	ective action must be taken.			
	Based on intervie	ew and record review, the	F0225	DisclaimerPreparation,	07/01/2012
		thoroughly investigate, or		submission and implementation of this Plan of Correction does	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 9 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPLE	TED
		15E594		LDING		06/01/2	012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					136TH ST		
MCGIVN	EY HEALTH CARE	CENTER		CARME	EL, IN 46033		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	report to ISDH I	Division of Long Term			constitute an admission of/or		
	Care immediately, one allegation of				agreement with the facts and		
	neglect [Resident #K] and one allegation				conclusions set forth on the		
	1 -	-			survey report. McGivney Hea		
		ion of property [Resident			Care reserves all rights to con	test	
	_	esidents reviewed for			the survey findings through		
	allegations of ab	use; in a sample of 10			informal dispute resolution, for	mai	
	residents reviewe	ed.			appeal proceedings or any Administrative or legal		
					proceedings. McGivney Healt	h I	
	Findings include:				Care reserves all rights to rais		
	Findings include.				all possible contentions and	Ĭ	
	Fallowing the entropy of conference on				defenses in any type of civil or		
	Following the entrance conference on				criminal claim, action or		
	5/29/12 at 10:30 A.M., the Administrator				proceeding. The facility offers	its	
	provided the inve	estigations the facility			responses, credible allegation:		
	completed for 3	allegations of abuse since			compliance and plan of correc		
	-	arvey on 3/18/11.			as part of its ongoing efforts to		
	the last annual se	11 vey on 3/16/11.			provide quality care to residen		
					McGivney Health Care reserve		
		vestigations the facility			the right to modify policies and	i/or	
	•	lew involved Resident			procedures and quality improvement systems as		
	#K, who alleged	that "no one had let her			necessary to better meet the		
	eat or drink all da	ay."			needs of the residents and the	.	
					facility.F 225 It is the mission		
	The "Investigative	ve Report for Suspected			this facility to provide its reside		
		• •			with a safe and pleasant		
		or Unusual Occurrence"			environment in which to live.	-	
		as completed by the			facility will endeavor to preven	t,	
	Social Service D	irector on 2/15/12, and			investigate, report the	_	
	indicated the foll	lowing:			mistreatment, neglect or abuse	e of	
					all residents and the		
	"Date and Time	of Occurrence: February			misappropriation of property. facility will not tolerate verbal,	ine	
					mental, sexual or physical abu	ا مور	
	10, 2012 [no time was listed]				corporal punishment or	130,	
					involuntary seclusion, nor will i	_{it}	
	Documentation of Complaint/Occurrence:				allow any staff member to pun		
	Resident stated to SSD [Social Service				a resident at any time during a		
	Director] that on	Saturday, February 11,			resident's stay in this facility.T		
	2012no one let	her eat or drink all day.			facility immediately investigate	ed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 10 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15E594	B. WIN			06/01/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			136TH ST		
MCGIVN	IEY HEALTH CARE	- CENTER			EL, IN 46033		
	•				1	T	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ION
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
					both unsubstantiated allegatio from Resident K and Resident		
	Interview and V	Vitness(es)/Staff			the day they were reported to		
	member(s)/Resi	dents: SSD and			SSD. The facility failed to repo		
	Administrator re	eviewed cameras that			the unsubstantiated allegation		
	showed the resi	dent did eat at meal times.			ISDH.No other residents were		
					affected by this practice. The		
	Follow-Un Acti	on Taken: Spoke with the			facility will immediately report		
	1	plained that we viewed the			ISDH, all allegations of neglec misappropriation of property fr		
	_	as eating/drinking at all			all residents whether	Jili	
	1 *	as cating/diliking at an			substantiated or unsubstantiat	ed.	
	meal times.				The Facility's Abuse Policy an		
					Procedure was reviewed and		
	_	OH or Other Officials in			revised. The Facility's		
	Accordance to S	State Law: No"			INVESTIGATIVE REPORT FO)R	
					SUSPECTED ABUSE,		
	In an interview	on 5/31/12 at 3:10 P.M.,			NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012)		
	the Social Servi	ce Director indicated the			form was revised. All Staff		
	resident came to	her on 2/15/12			in-service conducted on: MHC	С	
		e morning"she did not			ABUSE PREVENTION POLIC	Υ	
		hen, and reported the			AND PROCEDURE (JUNE 20	· ·	
	I	esident did not give her			and Reporting all Allegation of		
		· ·			Abuse (F225 and F226)All sta		
	1	e frame that the incident			are responsible to stop abuse report abuse immediately. Sta		
	1	ne SSD did not probe for			in-service on MHCC ABUSE		
	'	After the resident			PREVENTION POLICY AND		
	1 ^	ident, the SSD went to			PROCEDURE (JUNE 2012) a	nd	
	talk to the staff	about the incident, and			Reporting all Allegation of Abu		
	reported to the	Administrator. She had			(F225 and F226) was conduct		
	not documented	l, nor did she remember,			in June 2012 by the SSD/DON		
		poke with staff, and had			All new employees will receive and be in-serviced on the MH0		
	not kept documentation of which staff she interviewed, but all interviews were done "that morning." The SSD also indicated the camera monitoring tapes were				ABUSE PREVENTION POLIC		
					AND PROCEDURE (JUNE 20		
					upon hire. The DON/designed		
					the Abuse Investigation		
					Coordinator and will be		
	"reviewed that r	norning."			responsible for utilizing the		
					revised INVESTIGATIVE		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL			
		15E594	B. WIN	G		06/01/	2012		
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE				
					136TH ST				
MCGIVN	EY HEALTH CARE	CENTER		CARME	EL, IN 46033				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	In an interview a				REPORT FOR SUSPECTED ABUSE, NEGLECT, OR				
	Administrator indicated the incident was				UNUSUAL OCCURRENCE				
	not reported to ISDH because they had				(JUNE 2012). The Quality Assurance Committee will				
	reviewed the camera tapes and had								
	determined the resident had eaten at all meals. B. The second investigation involved Resident #C who alleged the Maintenance Supervisor took his Blue Tooth device.				monitor compliance of the facil	-			
					MHCC ABUSE PREVENTION POLICY AND PROCEDURE for				
					each incident on a quarterly	. .			
					basis.				
	The "Investigative Report for Suspected								
	Abuse, Neglect,	or Unusual Occurrence"							
	form was dated a	as completed by the							
	Social Service D	pirector on 3/15/12, and							
	indicated the foll	lowing:							
	"Date and Time	of Occurrence: March							
	13, 2012 [no tim	ne was listed].							
		-							
	Documentation of	of Complaint/Occurrence:							
		d to CNA that Blue							
		by staffMaintenance							
	man.								
	Interview with W	Vitness(es)/Staff							
		lents: Spoke with							
		pervisor]he never saw							
		Only was in room to							
	program the rem	•							
	program the rem	ote control.							
	Spoke with [C N	[.A.] [There was no							
	documentation o								
	information]	T THE HITCH VIC VV							
	mioimation								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 12 of 35

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(x2) MULTIPLE CONSTRUCTION A. BUILDING 00	COMPLETED
	15E594	B. WING	06/01/2012
	PROVIDER OR SUPPLIER EY HEALTH CARE CENTER	STREET ADDRESS, CITY, STA 2907 E 136TH ST CARMEL, IN 46033	ATE, ZIP CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIV CROSS-REFERENCE	VLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY) (X5) COMPLETION DATE
	Resident moved here on 2/27/12at that time he did not have his Blue Tooth for his phone. SSD asked him about it and why he did not have it in his ear. Resident stated he did not want to use it. SSD asked him where it was, he stated he did not know. It was not listed on his inventory sheet at admission. P.O.A. [Power of Attorney] called and told SSD he did not have a Blue Tooth and has not had one for weeks. P.O.A. was purchasing a new Blue Tooth and would bring it in. Reported to ISDH or Other Officials in Accordance to State Law: No" In an interview on 5/31/12 at 3:20 P.M., the Social Service Director indicated the resident requested to see her on 3/15/12, and reported the device was missing on 3/13/12. She interviewed the C.N.A. on 3/15/12, who did not remember when the resident told her about the missing deviceonly that he accused the Maintenance supervisor. The C.N.A. reported she only saw the device once on the night stand, but no date was given. The date and time the P.O.A. was contacted was not documented. In an interview at that time, the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 13 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMPL 06/01/	ETED
	PROVIDER OR SUPPLIER IEY HEALTH CARE CENTER	2907 E	ADDRESS, CITY, STATE, ZIP 136TH ST EL, IN 46033	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Administrator indicated the allegation was not reported to ISDH because they had determined, after speaking with the P.O.A., that the resident had not had a Blue Tooth device. This Federal tag relates to Complaint IN00107420. 3.1-28(c) 3.1-28(d)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 14 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15E594	A. BUILDING B. WING		06/01/2012	
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	L		E 136TH ST		
MCGIVN	EY HEALTH CARE	CENTER		EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0226 SS=D	ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property.	MENT ABUSE/NEGLECT, develop and implement and procedures that prohibit eglect, and abuse of sappropriation of resident ew and record review, the	F0226	DisclaimerPreparation,	07/01/2012	
	facility failed to Abuse Preventio investigation and	fully implement their n procedures, related to l reporting allegations, ions reviewed; for	10220	submission and implementation of this Plan of Correction does constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Head Care reserves all rights to conthe survey findings through	on s not	
	5/29/12 at 10:30 provided the invectompleted for 3 at the last annual su. A. One of the in	e entrance conference on A.M., the Administrator estigations the facility allegations of abuse since arvey on 3/18/11. vestigations the facility few involved Resident		informal dispute resolution, for appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to rais all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers responses, credible allegation compliance and plan of correct as part of its ongoing efforts to	th se r its s of ction	
	#K, who alleged eat or drink all d The "Investigative Abuse, Neglect, form was dated a	that "no one had let her ay." ve Report for Suspected or Unusual Occurrence" as completed by the		provide quality care to resider McGivney Health Care reserve the right to modify policies and procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility. F 226 It is the policy of	es d/or	
	indicated the foll	of Occurrence: February		facility to fully implement their Abuse Prevention Procedures related to investigations and reporting allegations. It is the mission of this facility to provide		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED
		15E594	B. WIN			06/01/2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			136TH ST	
MCGIVNI	EY HEALTH CARE	CENTER			EL, IN 46033	
			_		LL, IIV 40000	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	10, 2012 [no tim	ne was listed]			its residents with a safe and	4-
					pleasant environment in which	
	Documentation of	of Complaint/Occurrence:			live. The facility will endeavor prevent, report the mistreatme	
		o SSD [Social Service			neglect or abuse of all residen	
		Saturday, February 11,			and the misappropriation of	.
	_	her eat or drink all day.			property. The facility will not	
	2012 110 0110 101	nor out or arms an day.			tolerate verbal, mental, sexual	or
	Internia - 1337	::tu = = = (= =) / S t = C C			physical abuse, corporal	
	Interview and W				punishment or involuntary	
	member(s)/Resid				seclusion, nor will it allow any staff member to punish a resid	ent
		viewed cameras that			at any time during a resident's	CIIL
	showed the resid	ent did eat at meal times.			stay in this facility. The facility	
					immediately investigated both	
	Follow-Up Action	on Taken: Spoke with the			unsubstantiated allegations fro	om
	_	lained that we viewed the			Resident K and Resident C the	e
	1	s eating/drinking at all			day they were reported to the	
	meal times.	s caming at an			SSD. The facility but failed to	
	inear times.				report the unsubstantiated allegations to ISDH.No other	
	D 11 IOD	II Od OCC : 1 :			residents were affected by this	
	_	H or Other Officials in			practice. The facility will	
	Accordance to S	tate Law: No"			immediately implement the Ab	use
					Prevention procedures, related	d to
	In an interview of	on 5/31/12 at 3:10 P.M.,			investigation and reporting	
	the Social Service	e Director indicated the			allegations to the ISDH, all	
	resident came to	her on 2/15/12			allegations of neglect or	om
		morning"she did not			misappropriation of property fr all residents whether	UIII
		en, and reported the			substantiated or unsubstantiat	ed.
	1	sident did not give her			The Facility's Abuse Policy and	i i
		e frame that the incident			Procedure was reviewed and	
					revised.The Facility's	
	· ·	e SSD did not probe for			INVESTIGATIVE REPORT FO)R
	1 -	After the resident			SUSPECTED ABUSE,	
		dent, the SSD went to			NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012)	
	talk to the staff about the incident, and reported to the Administrator. She had				form was revised.All Staff	
					in-service conducted on: MHC	c
	not documented,	nor did she remember,			ABUSE PREVENTION POLIC	
	· · · · · · · · · · · · · · · · · · ·	oke with staff, and had			AND PROCEDURE (JUNE 20	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED
		15E594	B. WIN			06/01/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	2			136TH ST	
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	not kept docume	ntation of which staff she			and Reporting all Allegation of	
	interviewed, but all interviews were done				Abuse (F225 and F226)All sta	
	"that morning."	The SSD also indicated			are responsible to stop abuse	
		toring tapes were			report abuse immediately. Sta in-service on MHCC ABUSE	П
	"reviewed that m	.			PREVENTION POLICY AND	
	Teviewed that if	ioning.			PROCEDURE (JUNE 2012) a	nd
	In on intermite	t that time a tha			Reporting all Allegation of Abu	
	In an interview a	·			(F225 and F226) was conduct	
		dicated the incident was			in June 2012 by the SSD/DON	
	_	SDH because they had			All new employees will receive and be in-serviced on the MH0	
	reviewed the can	nera tapes and had			ABUSE PREVENTION POLIC	
	determined the r	esident had eaten at all			AND PROCEDURE (JUNE 20	
	meals.				upon hire. The DON/designee	
					the Abuse Investigation	
	B. The second in	nvestigation involved			Coordinator and will be	
		alleged the Maintenance		responsible for utilizing the		
		his Blue Tooth device.			revised INVESTIGATIVE REPORT FOR SUSPECTED	
	Supervisor took	ms Blue 100th device.			ABUSE, NEGLECT, OR	
	The "Investigation	va Danart for Sugmanted			UNUSUAL OCCURRENCE	
	1	ve Report for Suspected			(JUNE 2012). The Quality	
	_	or Unusual Occurrence"			Assurance Committee will	
		as completed by the			monitor compliance of the faci	· .
		pirector on 3/15/12, and			MHCC ABUSE PREVENTION	
	indicated the foll	lowing:			POLICY AND PROCEDURE f each incident and on a quarter	
					basis.	'y
	"Date and Time	of Occurrence: March			-	
	13, 2012 [no tin	ne was listed].				
	Documentation of	of Complaint/Occurrence:				
		d to CNA that Blue				
	1	by staffMaintenance				
	man.					
	111411.					
	Interview with V	Vitness(es)/Staff				
		dents: Spoke with				
	` ′	•				
	Liviaintenance St	ipervisor]he never saw				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 17 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15E594	B. WING		06/01/2012
NAME OF I	PROVIDER OR SUPPLIER	R	STREET .	ADDRESS, CITY, STATE, ZIP CODE	
				136TH ST	
MCGIVN	EY HEALTH CARE	CENTER	CARM	EL, IN 46033	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	 	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		Only was in room to			
	program the rem	note control.			
		I.A.] [There was no			
	documentation of	of the interview			
	information]				
		here on 2/27/12at that			
		nave his Blue Tooth for			
	his phone. SSD	asked him about it and			
	why he did not h	nave it in his ear.			
	Resident stated l	he did not want to use it.			
	SSD asked him	where it was, he stated he			
	did not know. It	t was not listed on his			
	inventory sheet a	at admission. P.O.A.			
	[Power of Attorn	ney] called and told SSD			
	he did not have a	a Blue Tooth and has not			
	had one for weel	ks. P.O.A. was			
	purchasing a nev	w Blue Tooth and would			
	bring it in.				
	_				
	Reported to ISD	H or Other Officials in			
	Accordance to S				
	In an interview of	on 5/31/12 at 3:20 P.M.,			
		ce Director indicated the			
		ed to see her on $3/15/12$,			
	•	device was missing on			
	_	terviewed the C.N.A. on			
		d not remember when the			
	· ·	about the missing			
	deviceonly tha	_			
	1	pervisor. The C.N.A.			
	_	y saw the device once on			
	reported sile only	y saw the device office off			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 18 of 35

STATEMEN	T OF DEFICIENCIES	CIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		URVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIH	LDING	00	COMPLE	ETED
		15E594	B. WIN			06/01/2012	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			136TH ST		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	·		Berielekery		DATE
	the night stand, t	out no date was given.					
	The date and time the P.O.A. was						
	contacted was no	ot documented.					
	In an interview a	t that time, the					
	Administrator in	dicated the allegation					
	was not reported	to ISDH because they					
		after speaking with the					
		resident had not had a					
	Blue Tooth device						
	Dide Tooth devik						
	2 On 5/31/12 fl	he Assistant Director of					
		d a two-page paper, not					
		use Policy" and a					
		not dated, titled "Abuse					
	1	edure (Including Elder					
	·	ne indicated these were					
	the current polici	ies and procedures.					
	The procedures i	ncluded, but were not					
	limited to, the fo	llowing:					
	" 1. The prob	lem or concern will be					
	investigated imn	nediately and corrective					
	_	resident safety					
		-					
	5. The Social Se	ervice Director and the					
	Administrator w						
		n the INVESTIGATIVE					
		SUSPECTED ABUSE,					
	NEGLECT, OR	·					
	· ·						
		form by investigating					
	the situation and	talking to involved					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 19 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15E594	A. BUII B. WIN			06/01/	
NAME OF E	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					136TH ST		
	EY HEALTH CARE			l	L, IN 46033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	individuals					,	
	_	rill be investigated in					
	accordance with	State Law					
		rator/designee will be					
	-	mplete a REPORTABLE					
		CURRENCE form within rrence and send to the					
	ISDH"	nence and send to the					
		relates to Complaint					
	IN00107420.						
	3.1-28(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 20 of 35

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		COMP	E SURVEY PLETED
		15E594	B. WING	-	06/0	1/2012
	PROVIDER OR SUPPLIER		2907	T ADDRESS, CITY, STATE, ZIP CO E 136TH ST MEL, IN 46033	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F0309 SS=D	WELL BEING Each resident minust provide the services to attain practicable physipsychosocial we the comprehensicare. Based on record facility failed to sounds of 2 of 2 and #J] who were for lung condition residents reviewed. Findings include 1. On 5/29/12, to initiated with the Director of Nursidentified Reside with care and record was reviewed with care and record was reviewed by the performance of the provided discongestive heart. A "Condition Characteristic and the provided discongestive heart."	Il-being, in accordance with ve assessment and plan of review and interview, the properly assess the lung residents [Residents #B e prescribed antibiotics ns; in a sample of 10 ed. : Dur of the facility was ADoN [Assistant ing] at 10:45 A.M. She ent #B as non-compliant quired oxygen therapy. :00 A.M., Resident #B's wed. Diagnoses	F0309	DisclaimerPreparation, submission and impleme of this Plan of Correction constitute an admission agreement with the facts conclusions set forth on survey report. McGivner Care reserves all rights the survey findings throu informal dispute resoluting appeal proceedings or an Administrative or legal proceedings. McGivney Care reserves all rights all possible contentions and defenses in any type of criminal claim, action or proceeding. The facility responses, credible alleg compliance and plan of the as part of its ongoing eff provide quality care to reserve and quality improvement systems as necessary to better meeneds of the residents a facility.F309 Resident #EResident #J Lung conditioning antibiotics. Resident #B	n does not of/or s and the y Health to contest ugh on, formal any Health to raise and civil or offers its gations of correction forts to esidents. The seserves es and/or st the nd the 3 and ditions are ger on	07/01/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 21 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED
		15E594	A. BUII B. WIN			06/01/2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L			136TH ST	
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE
	A "Medication A	Administration Record"			Resident # J have not had a	
	[MAR], dated 3/23/12, included, but was				negative outcome related to th	
	not limited to, "A	Amoxicillin 500			"lung conditions". All residents	
	· · · · · · · · · · · · · · · · · · ·	outh three times per day			have the potential to be affected There are currently no residen	
		ses were marked as given			with "lung conditions" at this tir	
	1	•			All residents who have ATB	
	Starting 3/23/12	through 4/3/12"			therapy related to "lung	
					conditions"/ URI will been	
	*	Up Charting" dated with a			monitored every shift by charg	
		/12 and end date of			nurse during course of ATB wi	
	3/31/12, included	d, but was not limited to,			interventions as indicated in th	
	"Reason: Antibi	otics for upper			facility's follow up documentati guidelines. Nursing staff has	OII
	respiratory infect	tion [URI] Monitor for			been re-educated on the facilit	tv's
		oms of temperature and			documentation guidelines for	, ,
	breath sounds"	•			"Lung conditions"/URI.The DO	N
	orcam sounds				is responsible for the re-educa	ting
	Т	1			the Charge Nurses on the	
	_	s charted; however, no			facility's documentation guidel	
		esident #B's lung sounds			for "Lung conditions"/URI by J 1, 2012. To ensure compliance	-
		d in the clinical record			The DON or designee will mor	
	for 4 days during	g antibiotic therapy from			for compliance utilizing facility	iitoi
	3/23/12 to 3/27/1	12.			audit tool weekly times 4 week	is,
					bi-monthly times for 2 months	
	On 3/27/12, no ti	ime, a "Nursing			and then quarterly until continu	
		luded, but was not			compliance is maintained for 2	
	limited to, "Lung				consecutive quarters. The resi	
		50 sourius cicar			of these audits will be reviewe by the CQI committee oversee	
	bilaterally"				by the ED.	511
	TOTAL .				,	
		nent of lung sounds was 7				
	1	/12, the last day of				
	antibiotic therapy	y.				
	On 5/31/12 at 12	:00 P M in an				
	interview, the ADoN indicated she did					
	· ·					
		er documentation to				
	provide regardin	g lung assessments on				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 22 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MUI A. BUILI B. WING	DING	INSTRUCTION 00	(X3) DATE S COMPL 06/01/	ETED	
	PROVIDER OR SUPPLIER		S. WING	STREET A 2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Resident B. She	indicated it is the					
	expectation of th	e nurses to document					
	lung sounds whe	n a resident was treated					
	for a lung condit	ion.					
	•	our of the facility was					
		e ADoN [Assistant					
		ing] at 10:45 A.M. she identified Resident					
	_	ewable with dementia,					
		·					
	behaviors, and pain.						
	On 5/31/12 at 9.	50 A.M., Resident #J's					
	record was revie						
		re not limited to, chronic					
	· ·	betes mellitus type II,					
	dementia, and go	• • •					
	A 'Nurse's Notes	" dated 2/7/12 at 2:30					
	P.M., included, b	out was not limited to,					
	"Resident [#J] co	omplained of ribs					
	hurting residen	it sent to emergency					
	room"						
		nange Form" dated 2/7/12					
	· · · · · · · · · · · · · · · · · · ·	cluded, but was not					
	limited to, "Start	· ·					
	1	00 milligrams now, then					
	250 milligrams e	every day for 4 days"					
	A "Condition Ch	uanga Form" datad					
		nange Form" dated included, but was not					
	1 ' '	ow-up chest x-ray from					
	-	nosis of pneumonia"					
	2///12 with thag	nosis of pheumoma					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 23 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15E594	B. WIN	G		06/01/2012
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE	
	5)/ U5 AL TU 0AD5	OENITED.			136TH ST	
MCGIVN	EY HEALTH CARE	CENTER		CARME	EL, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)	DATE
	A 11D E 11 I					
	A "Day Follow-Up Charting" with the					
		12 through 2/20/12,				
		s not limited to, "Reason:				
		py Monitor for signs				
		f: Adverse Reaction,				
	lung sounds"					
	T1 1					
		ng assessment found in				
		ord for 4 days from				
	2/8/12 through 2	/11/12.				
	A UDI ··· I D	N T (U 1 (1				
	*	rogress Notes" dated				
		, included, but was not				
		ory of present illness:				
		ht chest discomfort				
	Review of syster	ns: lungs:				
	diminishing"					
	A !! C - 1 11 Cl	F				
		nange Form" dated				
		, included, but was not				
		ident #J] sent to the				
		for evaluation and				
		est pain and crackles in				
	1 -	eline 100 milligrams by				
	mouth 2 times pe	er day for 10 days"				
	Than 1					
		ng assessment found in				
	Resident #J's rec	ora for 2/13/12.				
	A "Condition C1	uanga Farm" datad				
		nange Form" dated				
		, included, but was not				
		e Practitioner visited				
	with resident n	ew order for follow-up				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 24 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 06/01	LETED /2012
DER OR SUPPLIER	CENTER	2907 E	136TH ST	P CODE	
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO)	N SHOULD BE	(X5) COMPLETION DATE
st x-ray" ere were no lund 4 days of antion 6/12 through 2 5/31/12 at 12: erview, the AE have any further dident #J.	ing assessments for the dibiotic therapy from 2/20/12. 00 P.M., in an DoN indicated she did her documentation g assessments for		CROSS-REFERENCED TO THE DEFICIENCY)	IE APPROPRIATE	
	ER OR SUPPLIER EALTH CARE SUMMARY ST EACH DEFICIENCE EGULATORY OR 10 St x-ray" The were no lunct 4 days of anti 5/12 through 2 Tryiew, the AD have any furth funding the lunct fident #J. S Federal tag 1 0107420.	EALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) St x-ray" The were no lung assessments for the 4 days of antibiotic therapy from 5/12 through 2/20/12. 5/31/12 at 12:00 P.M., in an an arview, the ADoN indicated she did have any further documentation arding the lung assessments for ident #J. 5 Federal tag relates to Complaint 0107420.	TSE594 ER OR SUPPLIER EALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) St x-ray" The were no lung assessments for the 4 days of antibiotic therapy from 5/12 through 2/20/12. 5/31/12 at 12:00 P.M., in an riview, the ADoN indicated she did have any further documentation arding the lung assessments for ident #J. S Federal tag relates to Complaint 0107420.	TSE594 ER OR SUPPLIER EALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) St x-ray" The were no lung assessments for the 4 days of antibiotic therapy from 5/12 through 2/20/12. 5/31/12 at 12:00 P.M., in an riview, the ADON indicated she did have any further documentation arding the lung assessments for ident #J. S Federal tag relates to Complaint 0107420.	TSTREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) St X-ray" The were no lung assessments for the 4 days of antibiotic therapy from 3/12 through 2/20/12. 5/31/12 at 12:00 P.M., in an rview, the ADoN indicated she did have any further documentation ruding the lung assessments for ident #J. 5 Federal tag relates to Complaint 0107420.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 25 of 35

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15E594	B. WING		06/01/2012
NAME OF F	AN OLUMBER OR GURBLIEF		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R	2907 E	136TH ST	
MCGIVN	EY HEALTH CARE	CENTER	CARMI	EL, IN 46033	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0329 SS=D	UNNECESSAR' Each resident's from unnecessal drug is any drug dose (including excessive durati monitoring; or w for its use; or in consequences w should be reduc combinations of Based on a com resident, the fact residents who he drugs are not give antipsychotic drugs. Based on intervi facility failed to	drug regimen must be free ry drugs. An unnecessary when used in excessive duplicate therapy); or for ion; or without adequate ithout adequate indications the presence of adverse which indicate the dose and or discontinued; or any the reasons above. In prehensive assessment of a cility must ensure that ave not used antipsychotic wen these drugs unless ug therapy is necessary to condition as diagnosed and the clinical record; and se antipsychotic drugs dose reductions, and ventions, unless clinically in an effort to discontinue ew and record review, the properly monitor 1 of 1	F0329	DisclaimerPreparation, submission and implementation of this Plan of Correction does	
	resident who wa	s receiving Coumadin		constitute an admission of/or	
	[blood thinner] t	herapy for signs and		agreement with the facts and	
	symptoms of ble	eeding; in a sample of 10		conclusions set forth on the	
	residents review	ed. [Resident #25]		survey report. McGivney Hea	
	Findings include			Care reserves all rights to con the survey findings through informal dispute resolution, for appeal proceedings or any Administrative or legal	rmal
	reviewed on 5/3	0/12 at 10:55 A.M.		proceedings. McGivney Healt Care reserves all rights to rais	
	Diagnoses inclu	ded, but were not limited		all possible contentions and	`
	to, atrial fibrillat			defenses in any type of civil or	-

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 26 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15E594	B. WIN			06/01/2012
			J. WIIN		ADDRESS, CITY, STATE, ZIP CODE	I .
NAME OF P	PROVIDER OR SUPPLIER				136TH ST	
MCCIVAL	EV LIENI TLI CADE	CENTED			EL, IN 46033	
MCGIVIN	EY HEALTH CARE	CENTER		CARIVIE	EL, IN 40033	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	anticoagulant the	erapy, dementia, and			criminal claim, action or	
	history of a C.V.	A. [cerebral vascular			proceeding. The facility offers	
		"] with right upper			responses, credible allegation	
		2 2 11			compliance and plan of correc	
	extremity nemipa	aresis [paralysis].			as part of its ongoing efforts to	
					provide quality care to residen	
	The May 2012 pl	hysician order recap			McGivney Health Care reserve	
	[recapitulation] s	heet listed an order,			the right to modify policies and procedures and quality	J/UI
	1	a PT/INR [Prothrombin			improvement systems as	
	· ·	al Normalized Ratio]			necessary to better meet the	
		-			needs of the residents and the	
		Monday and Thursday.			facility.F329Resident #25 has	
		ombin time range is			no further incidents of bruising	
	10-14 seconds, a	nd an INR therapeutic			bleeding since survey. PT/INI	
	range is 2.0-3.0 f	for a person receiving			has been reviewed per MD 3	
		edication. The resident			times per week with Coumadii	
	_	n orders for Coumadin,			adjustments as necessary per	
					physician order. Any residents	on
		ng from 5.0 to 6.0 mg.			Coumadin/Warfarin have	
	" " "	y, based on current			potential to be affected. All)T/
	PT/INR lab resul	ts.			residents who have a critical F	71/
					INR secondary to Coumadin/ Warfarin therapy will be	
	On 3/26/12, the I	PT/INR was 34.1 / 3.29.			monitored every shift until non	
	· · · · · · · · · · · · · · · · · · ·	physician gave an order			critical PT/INR is	
		nadin for 2 days and			obtained.Nursing staff has bee	en
					re-educated on the facility's	
		nt dose of 5.5 mg. on			documentation and assessme	nts
	3/29/12.				for critical lab values related	
					Coumadin /Warfarin therapy.T	
	There was no do	cumentation/evidence in			DON is responsible to re-educ	cate
		d that licensed nursing			the Charge Nurses on the	
		ly checking the resident			facility's documentation and	
					assessments for critical lab	
		nptoms of bleeding on			values related Coumadin	
	the days the anti-	coagulant was held.			/Warfarin therapy by July 1, 2012. To ensure compliance,	
					The DON or designee will mor	
	On 4/9/12, the P	Γ/INR was 31.1 / 3.0.			for compliance utilizing facility	
		hysician gave an order to			audit tool weekly times 4 week	
	•	lin for 2 days and resume			bi-monthly times 2 months, an	
1	i noiu ine Couillac	iii 101 Z uavs allu lesuille	1		1,	-

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 27 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		15E594	B. WIN			06/01/	2012
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			136TH ST		
	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	C LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	on 4/12/12.				then quarterly until continued compliance is maintained for 2	,	
					consecutive quarters. The res		
	There was no do	cumentation/evidence in			of these audits will be reviewe		
	the clinical recor	rd that licensed nursing			by the QA committee oversee		
	staff were active	ly checking the resident			the ED.		
	for any signs/syr	nptoms of bleeding on					
	the days the anti	-coagulant was held.					
		-					
	On 4/23/12, the	PT/INR was 46.2 / 4.49.					
	On 4/23/12 the p	physician gave an order to					
	_	din on 4/23 and 4/25, and					
	repeat the PT/IN						
	There was no do	cumentation/evidence in					
	the clinical recor	rd that licensed nursing					
		ely checking the resident					
		nptoms of bleeding on					
		-coagulant was held.					
		Cougulant was note.					
	On 4/30/12, the	PT/INR was 62.0 / 6.06.					
	On 4/30/12, the	physician gave an order					
	to give Vitamin	K immediately by					
	_	jection, and hold the					
	Coumadin until	,					
	On 4/30/12, a "	DAY/HOUR					
	FOLLOW-UP A						
		orm was initiated. The					
	form indicated "	REASON: Critical PT					
	IN [sic] MONIT						
		s] OF: Bleeding,					
		iae, edema." There was					
		For each shift from 4/30					
		of each shift from 4/30					
	through 5/5/12.		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 28 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

		OVIDER/SUPPLIER/CLIA IFICATION NUMBER: 594	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP. 06/01	
	PROVIDER OR SUPPLIER EY HEALTH CARE CENT	ER	2907 E	ADDRESS, CITY, STATE, ZIP 136TH ST EL, IN 46033	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PERCEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	In an interview on 5/31 the Assistant Director indicated she had just initiated the Assessment She indicated she was other documentation the licensed nursing staff visigns/symptoms of ble episodes of elevated P 4/30/12 episode. 3.1-48(a)(3)	of Nursing formulated and nt Charting forms. unable to find any nat demonstrated were monitoring for eding for the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 29 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15E594	B. WIN			06/01/2012	
			ı	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2907 E	136TH ST		
	EY HEALTH CARE	CENTER		CARME	EL, IN 46033		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0371	483.35(i)	ır.					
SS=F	FOOD PROCUR	.E., RE/SERVE - SANITARY					
	The facility must						
		from sources approved or					
	considered satisf	factory by Federal, State or					
	local authorities;						
	(2) Store, prepare under sanitary co	e, distribute and serve food onditions					
	Based on observa	ation, interview and	F03	71	DisclaimerPreparation,		07/01/2012
	record review, th	e facility failed to label			submission and implementatio		
	food to indicate t	he date it was made or a			of this Plan of Correction does constitute an admission of/or	not	
	"use-bv" date: an	d failed to maintain			agreement with the facts and		
		lean, sanitary manner in 1			conclusions set forth on the		
		1 of 1 kitchenette. These			survey report. McGivney Hea	ilth	
		es had the potential to			Care reserves all rights to conf	test	
	•	esidents who ate meals			the survey findings through		
					informal dispute resolution, for appeal proceedings or any	mai	
	from the kitchen.				Administrative or legal		
	Findings include	:			proceedings. McGivney Healt Care reserves all rights to raise all possible contentions and		
	1. During the in	itial observation of the			defenses in any type of civil or		
	_	12 at 10:25 A.M., a plate			criminal claim, action or		
		frigerator was observed			proceeding. The facility offers		
		wiches covered with			responses, credible allegations compliance and plan of correct		
		label was present. On			as part of its ongoing efforts to		
		as a 6 X 6 X 8 inch			provide quality care to residen		
					McGivney Health Care reserve		
	-	containing food without			the right to modify policies and	l/or	
		ounter to the left of the			procedures and quality		
		a baking tray containing			improvement systems as		
		red with plastic wrap.			necessary to better meet the needs of the residents and the	!	
	This item did not	contain a label.			facility.F371The Dietary Manag		
					immediately threw away all	.	
	During an intervi	ew at this same time, the			unlabeled food/drinks in the		
	-	indicated the unlabeled			kitchen and kitchenette. The Dietary Manager immediately		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 30 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI — 06/01	
	PROVIDER OR SUPPLIER		STREET 2 2907 E	ADDRESS, CITY, STATE, ZIP CO 136TH ST EL, IN 46033	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR items in the refri salad sandwiches the unlabeled foo tray of lemon bas	ratement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) gerator were chicken s and chicken salad, and od next to the sink was a rs.	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY) removed the soiled skil the stove and placed in to be washed. The skil identified were cleaned and air-dried and appro stored. The Dietary Ma immediately re-trained	Illet from In the sink Illets	(X5) COMPLETION DATE
	three large skille three skillets was	ts stored as clean. One of s observed to contain due. The skillet handle		employee to label food sanitation requirements kitchen equipment food surfaces and utensils. kitchenette refrigerator immediately defrosted sanitized. All residents I potential to be affected Facility's Labeling Polic Procedure was reviewer revised. All dietary stain-service on the Label and Procedure and the Requirements regardin equipment food-contact and utensils. The Nursi Schedule form was reviewed form. The Dietary staff are sponsible for labeling the kitchen/kitchenette/proper location to put kequipment to be cleaned Dietary Manager is residently Manager is r	and the sergarding decontact. The was and have the decontact and have the decontact. The contact and have the decontact and deco	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet

Page 31 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15E594	A. BUII B. WIN	DING	00	COMPLETED 06/01/2012	
	PROVIDER OR SUPPLIER			2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	3. The Environm on 5/31/12 at 9:1 Maintenance Sup Administrator in The following was combination refriin the kitchenette dining room: A. One plate with with clear plastice.	nental tour task was done 5 A.M., with the pervisor and the			quarters. The housekeeping is are responsible to sanitize the inside kitchenette refrigerator daily. The CNAs are responsit for weekly defrosting the Kitchenette refrigerator and completing the Defrost Schedule form. The Charge Nurses are responsible to ensure the CNA defrost the refrigerator and complete the Defrost Schedule form. The DON is responsible ensuring the defrost schedule completed by CNAs/Charge Nurses and the Defrost Sched form is completed. The DON of designee will monitor for compliance utilizing facility aud tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The responsible of these audits will be reviewed by the QA committee overseer the ED.	ole ule s for is ule or dit d	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 32 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 06/01/	ETED
	ROVIDER OR SUPPLIER		•	2907 E	DDRESS, CITY, STATE, ZIP CODE 136TH ST L, IN 46033		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	there was no labe indicate what it we date to indicate we been made or the to be used/consur- A second plate we covered with clear	el on the plastic wrap to was, and there was no when the sandwiches had date by which they were med. with 2 sandwiches, ar plastic wrap. Each					
	however there we wrap to indicate was no date to in sandwiches had l	peanut butter with jelly; as no label on the plastic what it was, and there dicate when the been made or the date by to be used/consumed.					
	a red liquid. A p was loosely wrap cup. There was a plastic wrap to ic there was no date	Styrofoam cup half full of iece of clear plastic wrap oped over the top of the no label on the cup or the lentify what it was; and e to indicate when it had a date by which it was to ed.					
	Manager had been Dietary department charge. The new	en on vacation, and a new ent employee had been in employee had not been tems needed to be					
		ezer compartment had no I had an inch build-up of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 33 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
		15E594	B. WINC			06/01/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					136TH ST	
	EY HEALTH CARE	CENTER		CARME	EL, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		inside and outside walls		TAG	Dia lettike 1)	DATE
		ent. Part of the frost had				
	_	or. In an interview at				
		intenance Director and				
		dicated it looked like				
		t a soda pop in the freezer				
		ded," spilling the soda in				
	the freezer and the					
	inc neczei and u	ion necznig it.				
	The Administrate	or indicated the freezer				
	The Administrator indicated the freezer was scheduled to be defrosted on					
		omething had happened."				
	Wiondays, out so	omeumig nau nappeneu.				
	In an interview o	on 5/31/12 at 10:15 A.M.,				
	the Assistant Dir					
		g department was				
		efrosting the freezer				
		ice a month. On 6/1/12,				
		neet of paper titled				
	"Defrosting the F	Refrigerators" which was				
	_	2. The paper indicated				
		eed to be defrosted on the				
	_	every month by 3rd. shift				
	C.N.A.s." A che	ck-list was marked for				
	the 1st. and 15th.	. of May.				
	4. The "Retail F	Food Establishment				
	Sanitation Requi	rements, Title 410 IAC				
	7-24" effective 1	1/13/04 indicated the				
	following:					
		roomt og gmg=iff=4 i				
	` ′	ccept as specified in				
		efrigerated, ready-to-eat,				
	potentially hazar	dous food prepared and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 34 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15E594	A. BUII B. WIN	DING	00 	COMPL: 06/01/	ETED
NAME OF F	PROVIDER OR SUPPLIER		D. WIIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	EY HEALTH CARE				136TH ST EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIENG REGULATORY OR held in a retail fo	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) od establishment for 7-four (24) hours shall be		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	clearly marked to by which the foo the premises, solo one (1) of the ten combinations spe	o indicate the date or day d shall be consumed on d, or discarded, based on apperature and time excified as follows and the n shall be counted as day					
	surfaces and uten sight and touch. surfaces of cooki shall be kept free	quipment food-contact sils shall be clean to (b) The food-contact ng equipment and pans of encrusted grease er soil accumulations"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RFJG11

Facility ID: 000545

If continuation sheet Page 35 of 35